

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036415

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8888

STATE FILE NUMBER

FILED SEP 24 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN ST. Louis

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before

a. STATE

Mo

b. COUNTY

admission)

c. CITY

OR TOWN

ST. Louis

Inside Limits

Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

3209 IVANHOE

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS

(If outside, give location)

3209 IVANHOE

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED

(Type or print)

First

Louis

Middle

LETANOVSKY

Last

4. DATE OF DEATH

Month

Day

Year

SEPT 12

1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

5-2-1883

9. AGE (last birthday)

79

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SHOE REPAIRMAN

10b. KIND OF BUSINESS OR INDUSTRY

OWN

11. BIRTHPLACE (City and state or country)

AUSTRIA HUNGARY

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

UNKNOWN

13b. MOTHER'S MAIDEN NAME

UNKNOWN

14. NAME OF HUSBAND OR WIFE

CHRISTINA LETANOVSKY (Deed)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

CHRISTINA LETANOVSKY

Address

4025 HEALY CT.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hr

a.m.

Month, Day, Year

p.m.

20d. INJURY OCCURRED WHILE AT WORK

☐

NOT WHILE AT WORK

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

12:05 P

to

and last saw her

him alive on

Death occurred at

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Paul J. Simon

22b. ADDRESS

1300 Clark

22c. DATE SIGNED

9/14/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

SEPT 15, 1962

23c. NAME OF CEMETERY OR CREMATORY

S.S. PETER & PAUL Cem.

23d. LOCATION (City, town, or county)

ST. Louis

(State)

Mo

24. FUNERAL DIRECTOR

ADDRESS

Thomas Ruts 2906 Garrison

25. DATE RECD. BY LOCAL REG.

SEP 14 1962

26. REGISTRAR'S SIGNATURE

Robert Smith M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

101

102

103

104

105

106

107

108

109

110

111

112

113

114

115

116

117

118

119

120

121

122

123

124

125

126

127

128

129

130

1

Warner Case

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Barley Thompson*

Licensed Embalmer No.

4861

P. O. Address

St. Louis 19, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.